Supreme Court, U.S.
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No.

In the

Supreme Court of the United States

JANET CARR,

Petitioner,

versus

THE GATES HEALTH CARE PLAN,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

After the Administrative Review of an ERISA claim for benefits is complete, may a Health Care Plan add a new theory for denial of benefits, for the first time, after lawsuit has been commenced.

Is a Health Care Plan under ERISA entitled to deny payment for life-threatening complications arising from a non-covered procedure that was performed sixteen years earlier, if the Plan language excludes only the non-covered procedure itself.

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Petitioner, Janet Carr, respectfully requests that a writ of certiorari be issued to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Seventh Circuit is reported at 195 F.3d 292 and found at p.1a appended hereto. The opinion of the District Court is not published and can be found at p. 14a

STATEMENT OF JURISDICTION

The judgment of the United States Court of Appeals for the Seventh Circuit was entered on October 21, 1999. The Court of Appeals denied a timely petition for rehearing and suggestion for rehearing en banc on November 17, 1999. (p. 32a).

Jurisdiction is based upon a federal question. Janet Carr sued the Gates Health Care Plan alleging violations of the Employee Retirement Income Security Act, 29 U.S.C. §1132 (a)(1)(b).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

29 USCS § 1132 (1999)

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought--

(1) by a participant or beneficiary--

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

STATEMENT OF THE CASE

There are two fundamental questions in the case. First, whether an ERISA Health Care Plan may add a new theory of denial of benefits after the administrative review procedure is over and suit commenced. Second, whether an ERISA Health Care Plan, vested with discretionary authority, is entitled to deny benefits for life-saving medical treatment arising from complications of a non-covered procedure that occurred years before, when the Plan language excludes only the non-covered procedure itself.

A. Background of Case

Janet Carr underwent a gastric stapling procedure (commonly known as "stomach stapling") in 1979. After 1979, Janet Carr became a participant/beneficiary in the Gates Health Care Plan, an ERISA welfare-benefit plan. In 1995, Janet Carr required further surgeries to remedy life-threatening complications that arose from the original stapling. The Gates Health Care Plan refused to pay for the bills based upon the following exclusion contained in the Plan.

The plan will not pay for:

Gastric stapling for weight loss purposes.

This is the "gastric exclusion."

The "gastric exclusion" is the exclusion that Janet Carr challenged during the administrative review. The administrative challenge also entailed taking a deposition of the doctor who performed the surgery.

Janet Carr pointed out the treatment received by her was not gastric stapling; at best, the treatment in question was for life-threatening complications that arose some sixteen (16) years after the gastric stapling procedure occurred. The Plan didn't dispute that the treatment in question was not for gastric stapling itself: it argued that it had the authority to interpret the Plan language as to excluding gastric complications arising many years after the stapling was performed.

Janet Carr then filed suit, pursuant to ERISA, 29 U.S.C. §1132 (a)(1)(b), alleging the denial of benefits was arbitrary and capricious.

B. The Proceedings Below.

District Court Proceedings

The parties filed cross-motions for summary judgment. The Gates Health Care Plan, for the first time, added a *new* basis for denial:

> "The following are specifically excluded surgeries and benefits... cosmetic or surgical procedures [such as] any surgeries performed in connection with the enlargement, reduction,

> implantation or change in appearance of a portion of the body."

(Hereinafter the "cosmetic exclusion")

The administrative record had been closed, and this was the first time the Gates Health Care Plan utilized the cosmetic exclusion as a basis for denial.

The District Court granted the Gates Health Care Plan's motion for summary judgment. The cosmetic exclusion was applied. In addition, the Court indicated that treatment for complications of a non-covered procedure should be denied, even if there was dicta from the Seventh Circuit that seemed to indicate the contrary. Janet Carr appealed.

Seventh Circuit

The Seventh Circuit, in a two to one decision, affirmed the District Court. In doing so, the majority applied both exclusions, indicated that complications of a non-covered procedure should be covered, and applied a general exclusion (the cosmetic exclusion) over the specific exclusion (gastric stapling). The dissent noted that the Seventh Circuit, in dicta, indicated complications of a non-covered procedure should be covered, and that in making its decision, the majority applied an incorrect contractual interpretive technique by applying the general exclusion when a specific exclusion was present.

This petition followed.

REASON FOR GRANTING THE WRIT

I. THE PETITION SHOULD BE GRANTED BECAUSE THE DECISIONS BELOW CONFLICT WITH THE OTHER CIRCUITS' HOLDINGS WITH REGARDS TO HEALTH CARE PLANS THAT ADD A NEW THEORY OR BASIS FOR DENIAL OF BENEFITS AFTER THE INTERNAL APPEAL IS COMPLETE AND AFTER SUIT HAS BEEN FILED.

An ERISA plan should not be able to add a new theory or basis for denial of a claim after the administrative review process is completed and a lawsuit has commenced.

Although not in the ERISA statute itself, it is now recognized that a claimant must exhaust the appeals procedure prior to filing suit when challenging a decision to deny benefits. Failure to do so results in a bar to bringing the claim altogether. *See Amato v. Bernard*, 618 F.2d 559, 568 (9th Cir. 1980); *Robyns v. Reliance Standard Life Ins. Co.*, 130 F.3d 1231 (7th Cir. 1997).

There is a noticeable split in the Circuits on this important issue.

In *Smith v. Retirement Trust Fund*, 857 F.2d 587 (9th Cir. 1988), the Court held that a party need not advance every "theory" for its denial during the review stage. *Farley v. Benefit Trust Life Ins. Co.*, 979 F.2d 653, 660 (8th Cir. 1992) (a plan can present evidence at trial that was ignored during the review). *Wolf v. National Shopmen Pension Fund*, 728 F.2d 182, 186; 5 EBC 1257 (3rd Cir. 1984) (differentiating

claim exhaustion from theory exhaustion; the latter is permissible).

Some courts have indicated that if a new theory or evidence is presented, it should be remanded to the Plan for consideration. *Lugo v. AIG Life*, 852 F.Supp. 187 (S.D.N.Y. 1994); *Offut v. Prudential Life Ins. Co.*, 735 F.2d 948 (5th Cir. 1984); *See also Schrader v. Anthem Life Ins. Co.*, 147 F.3d 388, 398 n11 (5th Cir. 1998).

Other Circuits have barred the introduction of new theories added after the administrative review process, including, *Marolt v. Alliant Techsystems, Inc.*, 146 F.3d 617, 620 (8th Cir. 1998) (evidently ignoring *Farley*); *Sandoval v. Aetna Life*, 967 F.2d 377 (10th Cir. 1992); *Doe v. Group Hospitalization*, 3 F.3d 80 (4th Cir. 1993).

The Seventh Circuit has apparently taken yet another position in which new theories not set forth in the review process will be considered *de novo*. *Matuszak v. Torrington Company*, 927 F.2d 320, 322-23 (7th Cir. 1991).

This is an issue of critical importance because the administrative review process is a precursor to a litigant taking action to enforce his or her federally protected rights in a court of law. In this light, the claims review process, prior to litigation, should be viewed to be as important as the underlying statute itself.

In the instant case, Janet Carr, (the wife of a factory worker in Galesburg, Illinois) dutifully went through each step of the claims process, clearly setting forth the factual basis and theory of her appeal. The Gates Health Care Plan responded that it didn't have to pay because of the gastric

provision. Janet Carr then took a deposition of her treating doctor in Iowa City, Iowa based upon the representations made by the Gates Health Care Plan, and submitted the deposition to the Plan. After reviewing the deposition, Gates rejected Plaintiff Janet Carr's theory on the basis of the gastric exclusion. After exhausting her appeal, she sought redress in the courts, advancing her same argument to the District Court. During these court proceedings, the Gates Health Care Plan added an entirely new basis for denial, which was accepted by both the District Court and the Court of Appeals. Janet Carr did not foresee, nor could she challenge, this new denial because the administrative and factual record had already been closed.

Janet Carr respectfully submits that this is an issue of critical importance. Since the administrative review process is a precursor to suit, the standards for such an internal review should be scrutinized every bit as much as the law itself. Furthermore, by adding a new basis for denial after the mandated review process was completed, Janet Carr is being denied a basic right that Congress sought to afford her and other participants and beneficiaries of ERISA Plans. As it stands now, there is a clear split in authority amongst the Circuits, and there would also appear to be splits *within* certain Circuits.

Furthermore, millions of Americans are participants in ERISA Plans. Hence, such a decision will have far-reaching effects, and there needs to be some certainty with regards to the proper procedure in administrative review, particularly when one considers that ERISA was enacted in 1974 to promote uniformity across the country.

Janet Carr respectfully asserts that allowing plan administrators to add new bases for denials after the Administrative Record is finished defeats the entire purpose of having a claims review at all. Furthermore, it can be -- and apparently has been -- used as a clever method to deny a person's federally protected substantive rights under the statute.

II. AN ERISA HEALTH CARE PLAN SHOULD NOT HAVE THE AUTHORITY TO EXCLUDE BENEFITS FOR COMPLICATIONS OF A NON- COVERED PROCEDURE WHEN THE PLAN LANGUAGE EXCLUDES ONLY THE PROCEDURE ITSELF.

Janet Carr's Petition for Writ of Certiorari should be granted because the holding in Carr incorrectly extends an administrator's authority to interpret the plan language. In the instant case, throughout the mandated administrative review process, the basis for denial was as follows:

> "The following are specifically excluded services and benefits... gastric stapling or diversion for weight loss."

From this, the court has held that it was proper for the Plan to exclude payment for life-threatening complications that arose some sixteen years after the original surgery was performed. Somewhat surprisingly, it appears only one Court has -- in dicta -- dealt with this issue. *Fuller v. CBT Corp.*, 905 F.2d 1055 (1990). In *Fuller*, the beneficiary underwent a vasectomy reversal which, by the terms of the Plan, was not covered. Mr. Fuller suffered complications of the surgery,

and sought to have the treatment paid by the Plan. The Seventh Circuit noted the following:

> "Now even if a vasectomy reversal is not a covered procedure, an illness incident to the procedure - infection, **complications**, a iatroginec injury, whatever - **would be covered**. Playing tennis is not a covered procedure either, but if you are injured playing tennis your medical expenses are covered. The record contains a letter from Fuller's physician suggesting ... that the overnight stay was necessary because of complications resulting from the operation to reverse the vasectomy and remove the garanuloma, as distinct from being a necessary incident of a normal vasectomy reversal. But Fuller does not argue the point in this Court, and it is therefore forfeited...

Fuller at 1057-1058 (Emphasis added).

There appears to be no other guidance available from other circuits. However, this is a crucial issue insofar as the Seventh Circuit has now held that it is permissible for a plan to interpret the plan language is such a manner. There is considerable significance to this holding. For example, suppose an individual undergoes a tonsillectomy in 1970. At some point thereafter, the individual enrolls in a Health Care Plan which contains the following language:

> "The Plan does not pay for tonsillectomies."

In 2000, the individual suffers a life-threatening infection in the area of the aforesaid tonsillectomy. The individual, confident that such treatment is covered, submits the bills to the Plan for payment. The Health Care Plan then determines that if the individual did not have a tonsillectomy in 1970, there would be no infection in 2000, and therefore payment for the bills is denied...even though it is only the procedure itself which is excluded.

This is what occurred in the case at bar. Janet Carr underwent gastric stapling in 1979. In 1995, she faced life-threatening complications in the same area of her body, and submitted the more than $150,000 in bills to the Plan for payment. The Plan denied payment stating that the treatment was for complications of the gastric stapling, and because the Plan didn't cover the gastric stapling procedure itself, it wouldn't cover life-threatening complications occurring sixteen years later.

If this interpretive technique is allowed to stand, every person who may find themselves in the same or similar situation as Janet Carr will be denied coverage, even if the Plan only excludes the original procedure. This interpretation is replete with opportunities for abuse by health care plans.

Janet Carr's petition should be granted so that the court may determine, for the first time, that such a theory of denial of benefits is arbitrary and capricious.

CONCLUSION

This case presents a question of exceptional importance - whether an ERISA plan may add a new theory of denial of benefits after the administrative review process is complete, and after suit has been filed. The claims review is mandatory, and affects the federally protected rights of millions of Americans who are now enrolled in health care plans. This will allow this Court to have an opportunity to define the parameters of the claims review process. In addition, there exists a question of exceptional importance as to whether a plan has the authority to exclude benefits for complications arising from a non-covered procedure when the Plan language excludes only the procedure itself.

RESPECTFULLY SUBMITTED,

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(Any footnotes trail end of each document)

No. 99-1362

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

JANET CARR,
Plaintiff-Appellant,

v.

THE GATES HEALTH CARE PLAN,
Defendant-Appellee.

September 17, 1999, Argued

October 21, 1999, Decided

COUNSEL:
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For GATES HEALTH CARE PLAN, Defendant - Appellee: Gary D. Nelson, HEYL, ROYSTER, VOELKER & ALLEN, Peoria, IL USA. Brian J. Spano, ROTHGERBER, JOHNSON, LYONS, Denver, CO.

JUDGES:
Before Bauer, Flaum, and Ripple, Circuit Judges. RIPPLE, Circuit Judge, dissenting.

OPINIONBY:
BAUER

OPINION:

Bauer, *Circuit Judge.* Janet Carr was denied benefits under the Gates Health Care Plan ("the Plan"), an employee welfare benefit plan, because the treatment rendered related to a 1979 gastric stapling surgery, specifically excluded under the Plan. The Plan is sponsored by the Gates Corporation, and provides medical benefits, subject to certain limitations and exclusions, to eligible employees of the corporation and their dependants. The District Court held that the Health Care Benefits Review Committee ("the Committee") has sole discretion to interpret the Plan. After exhausting her administrative remedies, Carr initiated a suit under ERISA, *29 U.S.C. § 1132*(a)(1)(b), in state court to recover benefits under an employee welfare plan. The Plan then removed the case to the United States District Court of the Central District of Illinois. On cross-motions for summary judgment, the district court determined that the Plan did not arbitrarily and capriciously deny Carr's claim, granted the Plan's motion for summary judgment and denied Carr's motion. We affirm the district court's decision.

I. Background

In 1979, Carr underwent a gastric stapling procedure, not covered by the Plan, for the purpose of weight loss. In 1992, she sought treatment to revise the procedure at the University of Iowa Hospitals and Clinics in Iowa City, Iowa. This treatment was specifically excluded from coverage under the terms of the Plan. Carr appealed and the Plan agreed to cover the procedure but told her that "any future surgery related to

this specific condition could not be covered unless a benefit under the plan at that time."

In 1995, Carr suffered further complications from her 1979 surgery. Between June 21, 1995 and December 30, 1995 Carr underwent a series of surgeries to alleviate her condition. Carr submitted the bills for these surgeries to the Plan. After review of Carr's file, the Plan's Medical Director denied her claims under the Plan, which specifically excluded services and benefits for cosmetic or surgical procedures related to the enlargement, reduction, implantation or change in appearance of a portion of the body and gastric stapling or diversion for weight loss. Carr appealed this decision to the Committee, who retained independent physician specialist Dr. John Q. Gallagher. Carr submitted additional medical records and information for consideration by the specialist. Dr. Gallagher opined that the surgeries during June and December of 1995 were related to the original gastric surgery performed in 1979. After a final review, the Committee sent Carr a 10-page letter detailing its decision and reasoning for denying her claim. The Committee's decision was based on its policy to exclude conditions or problems directly or indirectly related to, or caused by, gastric stapling or weight-loss diversion procedures, even if the benefits and services are medically necessary.

Carr requested an additional review by the Committee. The Committee again reviewed her file and the transcript of the evidence deposition of her attending physician, Dr. Doherty. The Committee reaffirmed its decision that the treatment rendered was related to the gastric stapling procedure and therefore not covered under the Plan.

Carr then filed suit to have the Committees decision overturned.

II. Analysis

We review the district court's order granting summary judgment *de novo. Larsen v. City of Beloit, 130 F.3d 1278, 1281 (7th Cir. 1997).* Where the plan gives the administrator discretion to interpret the plan terms or determine benefits eligibility courts review the denial of benefit claims under ERISA, *29 U.S.C. § 1132*(a)(1)(b), using the arbitrary and capricious standard. *Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S. Ct. 948, 956-57, 103 L. Ed. 2d 80 (1989); Butler v. Encyclopedia Brittanica, Inc., 41 F.3d 285, 288 (7th Cir. 1994).* Under the arbitrary and capricious standard, the administrator's decision will only be overturned if it is "downright unreasonable." *Butler* at 291. A denial of benefits will not be set aside if the denial was based upon a reasonable interpretation of the plan documents. *Loyola Univ. of Chicago v. Humana Ins. Co., 996 F.2d 895, 898.* If the administrator makes an informed judgment and articulates an explanation for it that is satisfactory in light of the relevant facts, then the administrator's decision is final. *Id.* (quoting *Exbom v. Central States, Southeast and Southwest Areas Health and Welfare Fund, 900 F.2d 1138, 1141 (7th Cir. 1990).* Under the arbitrary and capricious standard, it is not our function to decide whether we would reach the same conclusion as the Plan or even rely on the same authority. *Cvelbar v. CBI Ill. Inc., 106 F.3d 1368, 1377 (7th Cir. 1997).* Instead, the court is only to determine if the decision was downright unreasonable. *Mers v. Marriott Int'l Group & Accidental Death and Dismemberment Plan, 144 F.3d 1014, 1021 (7th Cir. 1997).*

In this case, it is undisputed that the Committee is authorized, in its sole discretion, to interpret the Plan. This discretion empowers the Committee to construe disputed or ambiguous terms under the Plan, decide all questions of fact that may arise and determine the right of any member to a benefit, in accordance with the Plan. Under the Plan, such

interpretations or determinations made by the Committee in good faith shall be conclusive and binding on all parties.

Carr argues that treatment for life-threatening complications of a non-covered act should be covered. In support of her argument she relies on dicta from *Fuller v. CBT Corp., 905 F.2d 1055, 1057 (7th Cir. 1990),* which says that a complication incident to a non-covered procedure may be covered. The court in *Fuller,* however did not expand on this argument because the issue was not presented to the Court and therefore was waived. *Id.* Moreover, the *Fuller* court did not address the authority and the broad discretion of the plan administrator nor the scope of the plan at issue for us to comment. The court in *Fuller* did recognize the broad discretion of the plan administrator to interpret the plan and that the court will only overturn the decision if it was downright unreasonable. *Id. at 1058.*

In this case, the Committee was given the sole discretion to interpret disputed or ambiguous terms and therefore their decision can only be reviewed under the arbitrary and capricious standard. Only the Committee's interpretation was before the district court and it correctly held that the Committee acted reasonably.

Under the arbitrary and capricious standard we evaluate several factors: the impartiality of the decision making body, the complexity of the issues, the process afforded the parties, the extent to which the decision makers utilized the assistance of experts where necessary, and finally the soundness of the fiduciary's ratiocination. *Chalmers v. Quaker Oats Co., 61 F.3d 1340, 1344 (7th Cir. 1995).* Carr has admitted that the complications are due to the 1979 gastric stapling procedure. Her only claim is that the Committee's decision to deny benefits was arbitrary and capricious.

In 1992, Carr knew and acknowledged that the gastric stapling bypass procedure was not covered under the terms of

the plan but sought coverage on an exception basis. The Committee approved the procedure but specifically stated in a letter dated August 10, 1992, "The Committee agrees to cover this proposed surgery for Janet this one time only. Any future surgery relating to this specific condition cannot be covered unless a benefit under the Plan at that time."

While Carr was undergoing treatment for complications, Carr received a letter, in August 1995, from committee member, Dr. John Morrison, denying coverage. Dr. Morrison denied coverage because the treatment relates to the original and subsequent gastric stapling procedures. The letter also informs Carr of her right to submit new information and have her claim reviewed. Dr. Morrison reviewed her medical file in December 1995 and again denied her claim. He advised Carr that she could appeal the decision to the Health Care Benefits Review Committee.

Carr requested an appeal in August 1996, at which time the Committee retained an independent physician, Dr. Gallagher to review her file before the Committee made a final decision. Carr was allowed to supplement her file. In a December 1996 letter to the Committee Dr. Gallagher stated that in his opinion the complications and treatment between June and December of 1995 were related to her original gastric stapling surgery performed in 1979. In April 1997, the Committee issued a detailed ten page decision to Carr setting forth its reasons for denying her claim. In May 1997, the Committee reviewed Carr's file along with additional information submitted by Carr and issued a final denial in June, 1997.

The Committee in this case conducted an exhaustive review of Carr's medical file. Its judgment was informed and supported by sound ratiocination. It examined all of the evidence in depth. Carr had several opportunities to submit additional information for review. The Committee brought in

an outsider for independent analysis. He reached the same conclusion as the Committee; Carr's treatment was related to the original gastric stapling procedure.

Carr further argues that since the Plan is administered solely by agents and employees of Gates and her costs exceed $ 150,000.00 there is a conflict of interest. This circuit has already ruled that a conflict of interest such as this does not change the standard of review. *Chalmers, 61 F.3d at 1344; Van Boxel v. Journal Co. Employees' Pension Trust, 836 F.2d 1048 (7th Cir. 1987).* We presume that a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias or a significant conflict of interest. *Mers v. Marriott International Group Accidental Death and Dismemberment Plan, 144 F.3d 1014, 1020.* See *Cuddington v. Northern Ind. Public Serv. Co., 33 F.3d 813, 816 (7th Cir. 1994); Van Boxel, 836 F.2d at 1051, 1053.* The *Chalmers* court stated that if the corporation's financial interests were a cause for concern, ERISA would take measures to prohibit corporate officers from serving as plan administrators. *Chalmers, 61 F.3d at 1344.* Carr offers no evidence of a significant conflict of interest or actual bias against her. As the district court stated, the plan is funded by both employee contributions and corporate funds and Carr's costs would be insufficient to undermine the administrators' impartiality. In this case, the Committee has more than satisfied the factors listed in *Chalmers.*

Carr argues further that there are two factual flaws with the Committee's interpretation of the Plan language. First she argues that the treatment rendered was for complications of a 1979 gastric stapling procedure, not the procedure itself. Second, she argues that the treatment was to save her life, not for weight loss. The Court does not dispute this. As the district court pointed out, the Committee did not deny her coverage on the grounds of medical necessity. The committee

denied coverage because the treatment was directly related to the 1979 gastric stapling procedure which was for the purposes of weight loss or to reduce/reshape a portion of her body. The Committee interpreted their Plan to include complications related to the non-covered procedure itself. Specifically, the Plan states Exclusion and Limitations as:

> Exclusions. By way of example, but not of limitation, the following are specifically excluded services and benefits: . . . 2. Cosmetic or surgical procedures . . . [such as] any services performed in connection with the enlargement, reduction, implantation, or change in appearance of a portion of the body . . . 19. gastric stapling or diversion from weight loss.

The Court can only review the Committee's interpretation of the Plan, not the Plan language under the arbitrary and capricious standard. *Loyola, 996 F.2d at 898.*

The court in *Kraut v. Wisconsin Laborers Health Fund, 992 F.2d 113, 118 (7th Cir. 1993),* construed the phrase "in connection with" very broadly. The court focused on the purpose of the surgery not the location of it. *Id.* Carr argues that the purpose of the treatment was to save her life. However the purpose, when interpreting the Plan language, is connected with her 1979 surgery. Carr's treatment was for complications "connected with" or "related to" her 1979 gastric bypass surgery. Carr's condition was lifethreatening because of the 1979 surgery, not independent of it.

The Court in *Loyola* upheld the denial of benefits because the treatment was "related to" an experimental heart

transplant. *Loyola, 996 F.2d at 903.* In *Loyola,* as in this case, it is irrelevant that the complications were life threatening. *Id.* The Court stated, "it seems callous for Humana to deny coverage for a lifesaving procedure and thereafter deny all subsequent hospital expenses . . . Humana's humanity is not the issue here. This is a contract case and the language of the benefit plan controls." *Id.* The Court here is in the same position, the language of the Plan controls as does the Committee's ruling as long as it is reasonable. Here the Committee acted reasonably and their decision to deny coverage was not arbitrary and capricious.

III. Conclusion

We believe that the decision of the Committee to deny Carr coverage for the treatment rendered between June and December of 1995 was based on a reasonable interpretation of the Plan's language. For the reasons set forth above, the district court's decision is affirmed.

DISSENTBY:
RIPPLE

DISSENT:

RIPPLE, *Circuit Judge,* dissenting. The question in this case is whether the Gates Health Care Plan ("the Plan"), by denying Ms. Carr medical benefits for surgeries related to an excluded gastric stapling, interpreted the Plan contrary to its plain language, thus acting arbitrarily and capriciously.

As the majority notes, the Plan vests the Gates Health Care Plan Review Committee ("the Committee") with discretion to administer the Plan. This provision requires a reviewing court to overturn the Committee's decision only if it is arbitrary and capricious. *See Firestone Tire and Rubber Co.*

v. Bruch, 489 U.S. 101, 115, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989); Hightshue v. AIG Life Ins. Co., 135 F.3d 1144, 1147 (7th Cir. 1998). The court's review must be to determine if the Committee's interpretation of the Plan is unreasonable. *See Ross v. Indiana State Teacher's Ass'n Ins. Trust, 159 F.3d 1001, 1009* (7th Cir.), *cert. denied, 143 L. Ed. 2d 109, 119 S. Ct. 1113 (1998).* An interpretation is unreasonable if it conflicts with the plain language of the Plan. *See, e.g., Cozzie v. Metropolitan Life Ins. Co., 140 F.3d 1104, 1109 (7th Cir. 1998)* ("It is well established that it is the language of an ERISA plan that controls."); *Dewitt v. Penn-Del Directory Corp., 106 F.3d 514, 520 (3d Cir. 1997)* ("A plan administrator may have discretion when interpreting the terms of the plan; however, the interpretation may not controvert the plain language of the document."); *Canseco v. Construction Laborers Pension Trust, 93 F.3d 600, 606 (9th Cir. 1996)* ("We have consistently explained that 'trustees abuse their discretion if they . . . construe provisions of [a] plan in a way that clearly conflicts with the plain language of the plan.'" (quoting *Johnson v. Trustees of Western Conference of Teamsters Pension Trust Fund, 879 F.2d 651, 654 (9th Cir. 1989))), cert. denied, 520 U.S. 1118 (1997); O'Shea v. First Manhattan Co. Thrift Plan & Trust, 55 F.3d 109, 112 (2d Cir. 1995)* ("However, 'where the trustees of a plan impose a standard not required by the plan's provisions, or interpret the plan in a manner inconsistent with its plain words, or by their interpretation render some provisions of the plan superfluous, their actions may well be found to be arbitrary and capricious.'" (quoting *Miles v. New York State Teamsters Conference Pension & Retirement Fund Employee Pension Benefit Plan, 698 F.2d 593, 599 (2d Cir. 1983))); Loyola Univ. of Chicago v. Humana Ins. Co., 996 F.2d 895, 903 (7th Cir. 1993)* ("This is a contract case and the language of the benefit plan controls.").

1.

The majority opinion states that "the language of the Plan controls as does the Committee's ruling as long as it is reasonable." Slip op. at 8. I also believe the language of the Plan controls; I do not believe, however, that the Committee acted reasonably in interpreting the document contrary to its plain language. In my view, the majority pays far too little attention to the pertinent language of the Plan.[1] Examination of the language must be the first step in determining whether the Committee's interpretation is unreasonable.

2.

"Because this is a matter of interpretation of an ERISA plan, we look to federal common law principles of contract interpretation to guide our inquiry." *Ross v. Indiana State Teacher's Ass'n Ins. Trust, 159 F.3d 1001, 1011* (7th Cir.), *cert. denied, 143 L. Ed. 2d 109, 119 S. Ct. 1113 (1998).* "It is a well-settled principle of contract construction that where a contract contains both general and specific provisions relating to the same subject, the specific provision controls." *Medcom Holding Co. v. Baxter Travenol Lab., Inc., 984 F.2d 223, 227 (7th Cir. 1993).* In the current case, two provisions of the Plan are relevant to the issue before us: (1) cosmetic or surgical procedures and (2) gastric stapling. These provisions state in pertinent part:

> The following are specifically excluded services and benefits . . .
>
> 2. Cosmetic or surgical procedures [such as] any services performed in connection with the enlargement, reduction, implantation or

> change in appearance of a portion of the body.
>
> . . .
>
> 19. Gastric stapling or diversion for weight loss.

Because specific provisions control over general provisions, the gastric stapling exclusion applies here, not the cosmetic procedures exception. In examining the gastric stapling exclusion of the Plan, it is useful to contrast its language with the language of the cosmetic or surgical procedures exception. The cosmetic procedures exception extends to include "any services performed in connection with the enlargement, reduction, implantation, or change in appearance of a portion of the body." Notably, similar descriptive language does not follow the gastric stapling exclusion. The presence of such language in the cosmetic procedures exception, compared with the absence of such language in the gastric stapling exclusion, suggests strongly "gastric stapling" was not intended to include anything beyond the actual gastric stapling.

The majority opinion argues that the phrase "in connection with" should be read broadly, such that complications of the gastric stapling fall into the exclusions category. Although the majority's interpretation of *Kraut v. Wisconsin Laborers Health Fund, 992 F.2d 113, 118 (7th Cir. 1993)* is accurate, and the phrase "in connection with" should be read broadly, two flaws exist in its application of *Kraut* to Ms. Carr. First, the "in connection with" language is found in the cosmetic procedures exclusion. To lift the phrase from that exclusion, and apply it in the gastric stapling exclusion, is inconsistent with the plain language of the Plan. Seventeen exclusions are listed between cosmetic procedures and gastric stapling; to carry that phrase down to gastric stapling is not a

natural reading of the plain language. Second, this circuit in *Fuller v. CBT Corp., 905 F.2d 1055, 1057 (7th Cir. 1990)* recognized, in dicta, that complications of uncovered procedures should be covered. Ms. Carr admits her gastric stapling in 1979 should have been excluded from coverage. Her 1995 surgeries, however, were designed to remedy *complications* of gastric stapling, not gastric stapling. These procedures are entirely separate from her original surgery. Therefore, even though the Committee properly excluded the initial gastric stapling, her complications from the excluded gastric stapling should be covered.

The majority concludes that it "can only review the Committee's interpretation of the Plan, not the Plan language under the arbitrary and capricious standard." Slip op. at 7. However, by ignoring the unambiguous, plain language of the Plan, the Committee interpreted the document contrary to its plain language and therefore acted unreasonably. Accordingly, I respectfully dissent.

Footnotes

[1] The majority opinion states in part: "The Committee interpreted their Plan to include complications related to the non-covered procedure itself. . . . The Court can only review the Committee's interpretation of the Plan, not the Plan language under the arbitrary and capricious standard." Slip op. at 7.

No. 97-1376

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF ILLINOIS

JAN 11,1999

JANET CARR

Plaintiff,

v.

THE GATES HEALTH CARE PLAN,

Defendant.

ORDER

Now before the Court are cross motions for summary judgment by both Plaintiff, Janet Carr, and Defendant Gates Health Care Plan (the "Plan") The Court has subject matter jurisdiction to hear this case pursuant to 28 U.S.C. § 1331, as the cause of action arises under the Employee Retirement and Income Security Act ("ERISA") , 29 U.S.C. § 1132(a) (1) (b)

The Plan is an employee welfare benefit plan as defined by ERISA, and Plaintiff was a beneficiary under the Plan at all times relevant to this litigation. The operation, of the Plan is supervised and managed by Defendant Gates Health Care Benefits Review Committee (the "Committee") . The Committee consists of eight members, including the Vice President of Administration, the Corporate Medical

Director, the Administrator of the Gates Clinic, the Director of Compensation and Benefits, two management level associates from divisions other than administration, the Manager of Insured Benefits, and the Manager of the Gates Clinic Business Office. The Plan gives the Committee broad discretion to interpret the Plan, construe disputed or ambiguous terms, decide all questions of fact that may arise, and determine the rights of members to benefits under the Plan; the Plan further provides that such determinations are conclusive and binding when made in good faith.

Plaintiff underwent a gastric bypass procedure in 1979 for purposes of weight loss. In 1992, Plaintiff sought treatment to revise this procedure at the University of Iowa Hospitals and Clinics in Iowa City, IA. Although such a procedure was excluded from coverage under the terms of the Plan, the Committee acceded to Plaintiff's request and agreed to cover the procedure on an exception basis. However, she was advised in a letter dated August 10, 1992, that "(a)ny future surgery relating to this specific condition cannot be covered unless a benefit under the Plan at that time."

At some point, Plaintiff apparently began to experience abdominal discomfort. In December 1994, she became dissatisfied with the medical therapy she was receiving for her condition, and despite receiving cautions from her treating physicians, she became determined to address her problems through curative surgery. Consequently, on or about June 21, 1995, Plaintiff underwent exploratory surgery to determine the cause of her abdominal distress and repair a recurrent abdominal wall herniation at the incision site of her gastric bypass surgery. She received related treatment through December 30, 1995. It is undisputed that this medical

treatment was related to complications arising out of her gastric bypass procedure.

Plaintiff submitted the resulting medical bills totaling $155,579.53 to the Plan for payment, but the Plan refused to cover any of the charges in a letter of denial dated August 22, 1995. The stated reason for the denial of benefits was that the treatment was directly related to problems or conditions arising from prior gastric stapling or diversion for weight loss, and the terms of the Plan expressly exclude services and benefits for gastric stapling or diversion for weight loss procedures. On December 21, 1995, Plaintiff received another letter from the Plan explaining that the medical care provided to her since June 1995 was not a covered benefit.

Plaintiff then exhausted all mandatory administrative remedies provided her under the Plan. During the course of these administrative proceedings, the Committee retained an independent surgeon, Dr. John Q. Gallagher, to review Plaintiff's medical records and information regarding her claim. Dr. Gallagher then opined that Plaintiff's medical treatment from June 21, 1995 through December 30, 1995 was related to her original gastric bypass procedure in 1979. Based on a review of the available medical information, as well as Dr. Gallagher's opinion, the Committee determined that Plaintiff's medical treatment was not covered under the Plan, which it summarized in a letter of denial dated April 9, 1997.

On May 23, 1997, Plaintiff submitted additional evidence for the Committee's consideration, including a sworn statement from Dr. Cornelius Doherty. After reviewing this supplemental information, the Committee reconfirmed its denial of benefits in a letter dated July 25, 1997.

Plaintiff brought suit in the Circuit Court of Knox County, and the matter was removed to this Court on October 20, 1997. On July 7, 1998, Plaintiff moved for summary judgment on her complaint. The Plan responded and filed a cross motion for summary judgment in its favor. This matter is now fully briefed and ready for resolution. This Order follows.

Legal Standard

A motion for summary judgment will be granted where there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56 (c). The moving party has the responsibility of informing the Court of portions of the record or affidavits that demonstrate the absence of a triable issue. Celotex Corp. v. Catrett, 477 U.S. 317, 106 *S.Ct.* 2548, 2552 (1986). The moving party may meet its burden of showing an absence of material facts by demonstrating "that there is an absence of evidence to support the non-moving party's case." Id. at 2553. Any doubt as to the existence of a genuine issue for trial is resolved against the moving party. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 255, 106 S.Ct. 2505, 2513 (1986); Cain v. Lane, 857 F.2d 1139, 1142 (7th Cir. 1988)

If the moving party meets its burden, the non-moving party then has the burden of presenting specific facts to show that there is a genuine issue of material fact. Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp., 475 U.S. 574, 586-87, 106 S.Ct. 1348, 13 55-56 (1986). Federal Rule of Civil Procedure 56 (e) requires the non-moving party to go beyond the pleadings and produce evidence of a genuine issue for trial. Celotex Corp., 106 S.Ct. at 2553. This Court must then determine whether there is a need for trial whether, in other

words, there are any genuine factual issues that properly can be resolved only by a finder of fact because they may be reasonably resolved in favor of either party. Anderson, 106 S.Ct. at 2511.

Discussion

I. MOTIONS FOR SUMMARY JUDGMENT

Here, there is no dispute that the medical bills incurred by Plaintiff between June 20,1995 and December 30, 1995 were incurred as a result bf complications from her prior gastric stapling procedure. The only dispute is whether these medical expenses are covered expenses under the terms of the Plan, which include an exclusions section that provides in relevant part:

> [T] he following are specifically excluded services and benefits . . . 2. Cosmetic or surgical procedures [such as] any services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body . . 20. Gastric stapling or diversion for weight loss.

The Gates Health Care Plan in Detail at 24-25.

Plaintiff asserts that because the Plan excludes the gastric stapling procedure itself but is silent with respect to any complications arising from the procedure, expenses resulting from the medically necessary treatment of said complications should be paid by the Plan. The Plan argues that it correctly denied responsibility for payment of these expenses as they are related to or caused by the excluded

gastric stapling procedure and also fall within the cosmetic services exclusion. Therefore, the Plan argues that these are •not covered expenses. There does not appear to be any dispute that this determination was based upon the Committee's interpretation of the plan language.

A. Standard of Review

Plaintiffs bring suit pursuant to 29 U.S.C. § 1132(a)(1)(B) of ERISA, which authorizes a participant or beneficiary of an employee welfare benefit plan to bring a civil action "to recover benefits due to him under the terms of his plan . . . ." ' 29 U.S.C. § 1132 (a) (1) (B). A challenge to a denial of benefits brought under § 1132 (a) (1) (B) is to be reviewed *de novo* "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Phillips v. Lincoln National Life Ins. Co., 978 F.2d 302, 307 (7th Cir. 1992), citing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989); Hickey v. A.E. Staley Mfg. , 995 F.2d 1385, 1389 (7th Cir. 1993) . If the administrator has discretionary authority to determine benefits, the Court may overturn the administrator's decision only if it was arbitrary and capricious. Firestone, 489 U.S. at 115.

In this case, the Plan clearly vests the Committee with "the power to interpret The Plan, decide all questions of fact that may arise thereunder, and determine the right of any member to a benefit . . ." The Gates Health Care Plan in Detail at 31. The Plan reserves the right to "adopt reasonable policies, procedures, rules and interpretations which promote the orderly administration of the Plan" and further provides that any interpretations or determinations adopted by the Committee in good faith are binding. Id. ; Plan Summary at

27. The effect of these provisions is to entrust the Committee with virtually unconstrained discretionary authority to determine policies and eligibility for benefits, as well as the proper construction of the terms of the Plan. See Gallo v. Amoco Corp., 102 F.3d 918, 921 (7th Cir. 1996). Accordingly, the Court will apply the deferential arbitrary and capricious standard of review. *See* Fuller v. CBT Corp., 905 F.2d 1055, 1058 (7th Cir. 1990); Exbom v. Central States, Southeast and Southwest Areas Health and Welfare Fund, 900 F.2d 1138, 1142 (7th Cir. 1990)

B. Conflict of Interest

Plaintiff argues that because the Plan is funded in part by the Gates Corporation and is administered by officers and agents of the corporation, there is an inherent conflict of interest in the review of benefits and interpretation of the Plan language. Thus, Plaintiff contends that the degree of deference to be afforded the Plan should be reduced.

However, the Seventh Circuit has rejected these rationales as "undermined by a provision in ERISA which provides specifically that employers may appoint their own officers to administer ERISA plans even if the company is a 'party in interest.'" Chalmers v. Quaker Oats Co., 61 F.3d 1340, 1344 (7th Cir. 1995), *citing* 29 U.S.C. § 1108 (c) (3). Furthermore, "[t] he impact on a company's welfare of granting or denying benefits under a plan will not be sufficiently significant as to •threaten the administrators' partiality." citing Van Boxel v. Journal Co. Employees' Pension Trust, 836 F.2d 1048, 1051 (7th Cir. 1987) . The court went on to conclude that if the corporation's financial interests were of any great concern, ERISA would not permit corporate officers or agents to serve as plan administrators. Id.

Likewise, Plaintiff's conflict argument is unpersuasive in this case. The Plan is funded by both employee contributions and corporate funds. While the $150,000 in medical bills that forms the subject of this litigation may seem like a vast amount to the average person, it pales in comparison to the company's billion dollar sales revenues and stated operating profit of more than $90,000,000.00.[1] Thus, any impact on the company's financial well being would be insufficient to undermine the administrators' impartiality, and the Plaintiff has failed to show that any perceived conflict of interest could reasonably be deemed serious enough to warrant a change in the prescribed standard of review. See, Chojacki v. Georgia-Pacific Corp., 108 F.3d 810, 815-16 (7th Cir. 1997)

C. Coverage

The Plan covers allowable medical expenses, which are defined as:

> [A]ny medically necessary and reasonable costs that are included under any of the plans covering the person for whom claim is made. Allowable Expenses do not include any of the expenses listed in the Exclusions.

The Gates Health Care Plan in Detail at 2. This particular plan then excludes any cosmetic or surgical services performed in connection with the reduction or change in appearance of a portion of the body, as well as gastric stapling or diversion for weight loss. Id. at 24-25.

Even under the arbitrary and capricious standard of review, the Seventh Circuit has directed the consideration of several factors:

> The impartiality of the decisionmaking body, the complexity of the issues, the process afforded the parties, the extent to which the decisionmakers utilized the assistance of experts where necessary, and finally the soundness of the fiduciary's ratiocination.

Chalmers v. Quaker Oats Co., 61 F.3d 1340, 1343-44 (7th Cir. 1995) The Court has previously noted Plaintiff's failure to cast any serious doubt on the impartiality of the Committee. The issues are not complex, and in fact, are undisputed: Plaintiff's medical expenses were incurred as a result of complications from her previous gastric stapling procedure, the only issue is whether the Plan's decision to .deny Plaintiff's' claim for benefits was. arbitrary or capricious.

In 1992, Plaintiff acknowledged that her proposed gastric bypass procedure was not covered under the terms of the Plan, but sought coverage on an exception basis. Her claim was initially denied based on the exclusion for gastric stapling, as well as the exclusion of sequelae by practice. At Plaintiff's request, the Committee then reconsidered the situation and agreed to cover the surgery on an exception basis; she was warned that "(a) ny future surgery relating to this specific condition cannot be covered unless a benefit under the plan at that time." Letter dated August 10, 1992 at ¶ 3.

While Plaintiff was undergoing treatment for complications associated with her prior gastric bypass procedures, she received a letter from the company's medical director indicating that because she was continuing to have problems connected to the gastric stapling and related surgeries, the Plan would not provide coverage for her claimed expenses. The medical director reaffirmed this position in a letter dated December 21, 1995 and advised Plaintiff of her appeal rights. Plaintiff then appealed to the Committee.

In considering Plaintiff's appeal, the Committee requested the consultation and opinion of an independent physician specialist. In November 1996, Plaintiff submitted additional medical records and information for consideration by the independent specialist, which were forwarded to him for his review. In a letter dated December 16, 1996, the independent specialist stated that after reviewing the records of Plaintiff's hospitalizations and treatment from 1979 through 1995, it was his opinion that all of the events during this period were causally related to her original gastric surgery in 1979.

On April 9, 1997, the Committee issued a ten page decision informing Plaintiff that coverage was denied for her claim based on the information in the administrative record, the opinion of the independent specialist, and the terms of the Plan. The Committee's decision indicated that it had a policy of interpreting the exclusion for gastric bypass or diversion "to also exclude benefits and services for medical conditions or problems that are directly or indirectly related to, or caused by, gastric stapling or weight-loss diversion procedures, even if the benefits and services are medically necessary." The decision then goes on to cite numerous pieces of evidence in Plaintiff's medical record in support of its conclusion that her

treatment was to remedy conditions directly' related to her gastric bypass procedure and that she would not have required either surgery, hospitalization, or follow-up treatment in 1995 had she not chosen to undergo the 1979 procedure. Plaintiff was then provided the opportunity to pursue another appeal to the Committee or alternatively, to an arbitrator.

Plaintiff requested additional review by the Committee. In support of this appeal, she submitted the transcript of the evidence deposition of Dr. Doherty, her attending physician. After review, the Committee again denied coverage for the claim. The Committee determined that certain statements in Dr. Doherty's deposition were not wholly reliable based on the following: (1) there is no indication that he recently referred to Plaintiff's medical records; (2) he was unable to recall the correct date of Plaintiff's most recent surgery; (3) he appears to resort to his recollection of Plaintiff's treatment as distinguished from the many other cases he has treated through the years; (4) in some instances, he is only able to "kind of recall" aspects of Plaintiff's condition or problems and his recollection is then contrary to the objective medical evidence in the record. Despite these concerns, the Committee assumed that the evidence deposition was reliable and considered it with the other evidence in the administrative record, but ultimately determined that the deposition did not completely refute the Committee's rationale for denial as Dr. Doherty's statements therein were not supported by the medical records, reports, and correspondence which were prepared by himself and other treating physicians contemporaneously with the treatment in question.

While Dr. Doherty's testimony identified several other causes and contributing factors as possible sources of

Plaintiff's problems in 1995, the Committee found that these conditions were only identified or considered in connection with or as related to her prior gastric bypass procedures; in other words, the Committee deduced that Dr. Doherty did not identify any cause for Plaintiff's -1995 problems that he did not also relate to her prior gastric stapling procedures. Therefore, the Committee again concluded that the 1995 surgery and following treatment were directly related to her prior gastric bypass procedure and confirmed the denial of coverage for the second time. At that point, Plaintiff had exhausted her appeal rights with the Committee, but still retained the opportunity to submit the dispute to arbitration. Thus, Plaintiff was afforded considerable process in her attempt to challenge the denial of benefits under the Plan.

The Committee requested and received the professional opinion of an independent surgeon, Dr. John Q. Gallagher, who is not affiliated with either the Plan, the Committee, or Plaintiff. The record demonstrates that Dr. Gallagher was given the extensive administrative record, as well as the additional information supplied by Plaintiff, f or his review and consideration. He then opined that all of Plaintiff's extensive treatment from 1979 through 1995 was related to her original gastric bypass procedure in 1979. An independent medical expert's review of the appropriate records may provide a reasonable basis for an ERISA plan's decision to deny benefits. Michael Reese Hospital & Medical Center v. Solo Cup Employee Health Benefit Plan, 899 F.2d 639, 641 (7th Cir. 1990)

Plaintiff challenges the soundness of the Committee's rationale as contrary to Seventh Circuit precedent in Fuller v. CBT Copr., 905 F. 2d 1055 (7th Cir. 1990). In Fuller, the Seventh Circuit did venture in dicta that even if a particular

procedure was not covered, "an illness incident to the procedure infection, complications, a iatrogenic injury, whatever - would be covered." Id. at 1057. Thus, there is certainly a hint of potential legal support for Plaintiff's interpretation of the terms of the Plan. However, it is not the province of the Court in this case to render a de novo interpretation of the Plan language; that job rests soundly with the Committee, and the opinion in Fuller did not attempt to address whether it would be arbitrary an abuse of discretion for a fiduciary to interpret the plan language as the Committee has done in this case.

Similarly, Plaintiff urges the Court to interpret the terms of the Plan in the light most favorable to her, construing any ambiguities against the Plan. If this case were subject to de novo review, the Court would readily agree with her position and would likely reach a different result. However, this general rule of construction is only appropriately implemented where courts have the authority to interpret the terms of the plan at issue. Morton v. Smith, 91 F.3d 867, 871 (7th Cir. 1996) . Here, the Committee is vested with far-reaching discretionary authority to construe the terms of the Plan and determine eligibility for benefits, so it is the Committee's interpretation of the Plan that is before the Court, and there is no occasion to engage in a de novo construction of the Plan language. Id.

Plaintiff also makes much of the fact that her 1995 surgeries and treatments were not for purposes of weight loss, but rather were to correct a potentially life-threatening medical condition that just happened to come about as a result of complications from her past gastric bypass surgeries. The Court does not necessarily disagree with her on this point. Nevertheless, the expenses were not denied because they were not medically necessary; they were denied because

they were found to be directly related to a prior gastric bypass procedure that was done primarily for purposes of weight loss or to reduce/reshape a portion of her body, and the Committee has interpreted the language of the Plan to include expenses for complications directly or indirectly related to the excluded procedure itself.

If the Court were to engage in a de novo construction of the Plan language, it would likely interpret the Plan differently from the Committee's construótion and may also disagree with its ultimate decision to deny benefits in this case, but in this case, the Court cannot reverse the Committee's determinations simply because it would have done things differently. The Committee's decision cannot be overturned unless the Court can find that the Committee abused its discretion, "which is to say, that they were not just clearly incorrect but downright unreasonable." Fuller, 905 F.2d at 1058, *citing* Disher v. Information Resources, Inc., 873 F.2d 136, 140 (7th Cir. 1989). Although the Court finds the Committee's interpretation of the Plan language and medical evidence to be somewhat attenuated, the parties have not presented, and the Court is otherwise unaware of, any authority establishing that the fiduciary's discretionary interpretation of an exclusion to include benefits for expenses that are found to be directly or indirectly related to, or caused by, the excluded procedure is patently unreasonable or arbitrary.

This is not a case where the Committee failed to give adequate consideration to the opinions of Plaintiff's treating physicians in order to adopt an opinion by a consultant that was flatly contradicted by all other medical evidence in the record. Rather, during the lengthy administrative review process, the notes and statements of Plaintiff's treating physicians, as well as the other medical evidence amassed, were

given considerable attention. Where the Committee discounted an opinion favorable to Plaintiff, its reasoning and evidence in support of its decision were adequately set forth.

The Seventh Circuit has held that under the arbitrary and capricious standard of review, the decision of a plan fiduciary should not be reversed "if it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome." Exbom, 900 F.2d at 1142, quoting Pokratz v. Jones Dairy Farm, 771 F.2d 206, 209 (7th Cir. 1985) . Here, there is certainly sufficient evidence from which, the Committee could rationally and reasonably conclude that Plaintiff's extensive history of surgery and treatments were either directly or indirectly related to her prior gastric bypass procedures.[2] Plaintiff is asking the Court to reweigh the evidence before the Committee to arrive at a more favorable result; this the Court will not do. In light of the Committee's policy and practice of interpreting the Plan exclusion to encompass complications or sequelae arising directly or indirectly from the excluded procedure and the facts before it, the reasonable.[3]

Finally, there has been no adequate showing that the Committee ignored relevant evidence submitted in support of Plaintiff's position, was not adequately informed, or otherwise failed to act in good faith in rendering its decision. If "the trustee has based its decision 'on a consideration of the relevant factors' that encompass the 'important aspect[s] of the problem' before it," the reasonable denial of a claim will not be set aside. Exbom, 900 F.2d at 1143, *citing* Reilly v. Blue Cross & Blue Shield United of Wisconsin, 846 F.2d 416, 420 (7th Cir. 1988); see also, Smart v. State Farm Ins. Co., 868 F.2d 929, 936 (7th Cir. 1989) (recognizing that if the trustee makes an informed judgment and articulates an

explanation for a denial that makes a "rational connection" between rationale for the denial of Plaintiff's claims would have been the issue under consideration, the available evidence, and the conclusion reached, then the decision of the trustee is final.) Accordingly, the Court cannot conclude that the denial of benefits in this case .was arbitrary, capricious, or downright unreasonable, and the decision of the Committee will not be overturned.

The Court is not unsympathetic to Plaintiff's situation. The record reveals that she has undergone extensive medical treatment for most of the last twenty years in an effort to combat her problems, and there is no doubt that she has endured considerable pain at times. The Committee's s decision 'also has the practical effect of exposing her to unlimited future liability for any additional cônsequences:that can be linked to a poor decision that she made almost twenty ago, which in some 'respects may seem ünf air.' However, the Court's sympathy cannot change the terms of the employee benefit plan at issue or federal law in order to achieve a more compassionate result. Finding no genuine issue of fact material to the inquiry in this case, the Court finds that summary judgment is appropriately granted in favor of the Plan.

II. AMENDED COMPLAINT

Plaintiff seeks leave to file an amended complaint that adds a breach of fiduciary duty count against the Committee. The allegations in this proposed count mirror those set forth with respect to her claim against the Plan for failure to pay benefits that has been addressed previously in this Order. The Court has serious doubts that Plaintiff can bolster her wrongful denial of benefits claim to maintain an

independent claim for breach of fiduciary duty on the same grounds. See Lister v. Stark, 1989 WL 88241 (N.D.Ill. August 1, 1989)

However, even assuming that such a claim can properly be brought, in light of the Court's ruling upholding the Plan's denial of benefits in this case and the substantial similarity of the allegations contained in the proposed count, the proposed amendment would not be viable. Accordingly, allowing the motion to be filed would be an exercise in futility, and the Motion for Leave to File Amended Complaint [#11] is therefore DENIED.

Conclusion

For the reasons set forth herein, Plaintiff's Motion for Leave to File Amended Complaint [#11) is DENIED, Plaintiff's Motion for Summary Judgment [#12] is DENIED, and Defendants' Motion for Summary Judgment [#16] is GRANTED. This matter is now terminated.

Entered this _____ day of January, 1999.

JOE BILL McDADE
Chief United States
District Judge

Footnotes

[1]These computations are based on a conversion rate of 1 United States Dollar = .6 British Pound.

[2] The letters from Dr. Truszkowski and Dr. Gallagher, as well as the General Surgery Progress Notes of Dr. Doherty, come immediately to mind as supporting the Committee's decision.

[3] Furthermore, Plaintiff's gastric bypass procedures and continued attempts to sustain weight loss through surgical means (as evidenced by her physicians' notes and correspondence) are literally "services performed in connection with the . reduction . . . or change in appearance of a portion of the body". Thus, the Committee could also reasonably interpret the much broader cosmetic procedures exclusion to encompass the expenses incurred as a result of Plaintiff's 1995 treatments. *See* Exbom v. Central States, Southeast and Southwest Areas Health and Welfare Pund, 900 F.2d 1138, 1143-44 (7th Cir. 1990) (affirming denial of benefits based on recognition that gastric bypass procedures fall within cosmetic surgery exclusion of employee benefit plan); Livingston v. Central States, Southeast and Southwest Areas Health and Welfare Fund, 900 F.Supp. 108, 115-16 (E.D. Mich. 1995).

No. 99-1362

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

JANET CARR,
Plaintiff-Appellant,

v.

THE GATES HEALTH CARE PLAN,
Defendant-Appellee.

November 17, 1999

Before Bauer, Flaum, and Ripple, Circuit Judges.

ORDER

Plaintiff-appellant has filed a petition for rehearing or petition for rehearing en banc. No judge in regular active service has requested a vote on the petition for rehearing en banc and all of the jdges on the panel have voted to deny rehearing . The petition rehearing is therfore DENIED.

Supreme Court, U.S.
FILED
MAR 14 2000
CLERK

(2)

No. 99-1363

In The

Supreme Court of the United States

JANET CARR,

Petitioner,

v.

THE GATES HEALTH CARE PLAN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

RESPONDENT'S BRIEF IN OPPOSITION

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1 Opp

QUESTION PRESENTED

Respondent disagrees with the Questions Presented by the Petitioner. Respondent presents the proper Question Presented, based upon Petitioner's Petition for a Writ of Certiorari, as follows:

Applying the arbitrary and capricious standard of review under ERISA, did the Seventh Circuit Court of Appeals correctly affirm the District Court's grant of summary judgment in favor of the Respondent on the grounds that the determination to deny benefits to Petitioner was not "downright unreasonable?"

LIST OF PARTIES TO THE PROCEEDING

Respondent The Gates Health Care Plan is sponsored by The Gates Corporation. The Gates Corporation is a wholly owned subsidiary of Tomkins US Holdings S.a.r.l., which is owned by Tomkins plc. There are no publicly held companies owning 10% or more of the stock of Respondent's sponsor, The Gates Corporation.

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STATEMENT OF JURISDICTION

The order and opinion of the Seventh Circuit Court of Appeals affirming the judgment of the United States District Court for the Central District of Illinois was entered on October 21, 1999. *Carr v. The Gates Health Care Plan,* 195 F.3d 292 (7th Cir. 1999). The Seventh Circuit Court of Appeals denied a Petition for Rehearing and Suggestion for Rehearing En Banc on November 17, 1999.

Petitioner's Petition for a Writ of Certiorari was docketed on February 15, 2000. Respondent acknowledges that if the case below otherwise presented a proper case for certiorari, jurisdiction would be proper under 29 U.S.C. § 1132(a)(1)(B), but Respondent denies that Petitioner presents a proper case for certiorari.

STATEMENT OF THE CASE

Petitioner's Statement of the Case contained in her Petition for a Writ of Certiorari fails to set forth several relevant facts in this case. In this action, Petitioner asserted a single claim for relief under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), for benefits allegedly due as a result of medical treatment received by her for complications arising from prior gastric bypass surgeries. During the relevant time period, Petitioner was a beneficiary under The Gates Health Care Plan ("Plan"), which is an employee welfare benefit plan governed by the provisions of ERISA.

The Plan is sponsored by The Gates Corporation, and provides medical benefits, subject to certain limitations and exclusions, to eligible employees of The Gates Corporation and their dependents. Under the Plan, the Health Care Benefits Review Committee ("Committee") is authorized, in its sole discretion, to interpret the Plan, construe disputed or ambiguous terms, decide all questions of fact that may arise under the Plan, and determine the right of any member to a benefit under the Plan. Pursuant to the terms of the Plan, the Committee's good faith interpretations and decisions are conclusive and binding on all parties.

At all relevant times, the Plan contained provisions which excluded coverage for "any services performed in connection with the . . . reduction . . . or change in appearance of a portion of the body" ("cosmetic exclusion"), and "gastric stapling or diversion for weight loss" ("gastric exclusion"). In addition to these Plan exclusions, Petitioner was advised by Respondent, in writing, in August 1992, three years before the medical treatment at issue in this action, that any future surgeries related to her gastric bypass procedures would not be covered by the Plan.

From June-December 1995, Petitioner received medical care for complications arising from prior elective gastric bypass procedures. After Petitioner demanded that Respondent pay for the medical expenses related to her treatment for complications of her prior gastric bypass procedures, the Committee met on several occasions to review and consider her claim. The Committee gathered and reviewed Petitioner's medical records, and additional information submitted by Petitioner's counsel and

her treating physician. The Committee retained an independent physician to assist it in evaluating Petitioner's claim for benefits. Ultimately, the Committee determined that the benefits requested by Petitioner were excluded from coverage under the Plan because Petitioner's medical treatment was directly related to her prior gastric bypass procedures. On July 25, 1997, the Committee sent a detailed 10-page letter to Petitioner setting forth the reasons for its determination that the Plan did not provide coverage for the benefits claimed.

Following the commencement of this action, Petitioner and Respondent filed cross-motions for summary judgment. Respondent asserted that it was entitled to summary judgment on the grounds that, under the arbitrary and capricious standard of review, Respondent's decision to deny Petitioner's claim for benefits should be upheld. In its Motion, Respondent relied upon the cosmetic exclusion and gastric exclusion as the principal grounds for denial of Petitioner's claim for benefits. Significantly, Petitioner did not contest the propriety of Respondent's reliance upon the cosmetic exclusion as a basis for denial of Petitioner's claim, but argued the application of the exclusion to the facts of the case.

On January 11, 1999, the United States District Court for the Central District of Illinois entered its Order denying Petitioner's Motion for Summary Judgment and granting Respondent's Motion for Summary Judgment. *See Order of the United States District Court for the Central District of Illinois, pp. 14(a)-31(a), attached to Petitioner's Petition for a Writ of Certiorari.* The District Court upheld Respondent's reliance upon the cosmetic exclusion and gastric exclusion in denying Petitioner's claim for benefits.

Petitioner appealed the adverse judgment to the Seventh Circuit Court of Appeals. Again, at no time during the appeal did Petitioner challenge the authority of Respondent to rely upon the cosmetic exclusion. The cosmetic exclusion was discussed, in detail, by the Seventh Circuit Court of Appeals in its opinion affirming the summary judgment in favor of Respondent. *See Opinion of the United States Court of Appeals for the Seventh Circuit, pp. 1(a)-13(a), attached to Petitioner's Petition for a Writ of Certiorari.*

SUMMARY OF ARGUMENT

Petitioner improperly seeks to persuade this Court to address issues set forth in her Petition for a Writ of Certiorari that were not raised in the proceedings before either the United States District Court for the Central District of Illinois or the Seventh Circuit Court of Appeals. Petitioner asserts that the central question presented to this Court is whether the Respondent may "add a new theory for denial of benefits, for the first time, after lawsuit has been commenced." *See Petitioner's Petition, Questions Presented.* Petitioner argues that Respondent should not be permitted to rely upon the cosmetic exclusion found in the Plan as a basis for denial of Petitioner's claim. This is the first time in this case that Petitioner has raised this issue as an alleged basis for overturning Respondent's denial of benefits to Petitioner.

The law is well-settled that Petitioner's failure to raise this issue in the proceedings below waives Petitioner's right to assert it for the first time before this

Court. At no time during the proceedings below did Petitioner ever challenge the propriety of Respondent's reliance upon any of the terms of The Gates Health Care Plan, including the cosmetic exclusion, in denying benefits to Petitioner. Instead, Petitioner argued the application or interpretation of the Plan exclusions relative to the facts of the case. Petitioner has waived her right to assert the first Question Presented in her Petition for a Writ of Certiorari.

In addition, as the United States District Court for the Central District of Illinois and the Seventh Circuit Court of Appeals have determined, summary judgment in favor of Respondent and against Petitioner was appropriate because, under the arbitrary and capricious standard of review, Respondent's denial of Petitioner's claim for benefits was not "downright unreasonable." Petitioner does not challenge the fact that she was afforded a full and fair opportunity to present her claim for benefits. The Respondent afforded Petitioner exemplary process in connection with its review of her claim, gathered Petitioner's medical information, received and considered the arguments and opinions of her treating physician and legal counsel, and was advised by an outside medical specialist. Respondent's decision that the Plan terms precluded coverage for Petitioner's claim for benefits reflected an informed judgment that was supported by sound rationale.

ARGUMENT

I. Petitioner Impermissibly Seeks To Raise New Issues In Her Petition For A Writ of Certiorari Which Have Been Waived Because Petitioner Failed To Present Them To The Courts Below.

In her Petition for a Writ of Certiorari, Petitioner impermissibly seeks to raise entirely new issues that were not raised in any of the proceedings below. For the first time, Petitioner now seeks to challenge the propriety of Respondent's reliance upon the cosmetic exclusion contained in the Plan. This argument was not raised in any of the proceedings below and has, therefore, been waived by Petitioner.

It is well-established that issues not raised before a lower court are deemed waived on appeal. *See, e.g., Town of Hallie v. City of Eau Claire,* 471 U.S. 34, 41, n.5, 105 S. Ct. 1713, 85 L. Ed. 2d 24 (1985); *Hormel v. Helvering,* 312 U.S. 552, 556, 61 S. Ct. 719, 85 L. Ed. 1037 (1941); *Bell v. Purdue University,* 975 F.2d 422 (7th Cir. 1992). Moreover, Petitioner's failure to contest Respondent's reliance upon a Plan term in connection with the cross-motions for summary judgment filed in the United States District Court for the Central District of Illinois waives Petitioner's right to raise this issue now. *See Liberles v. County of Cook,* 709 F.2d 1122, 1126-27 (7th Cir. 1983).

Significantly, Petitioner had every opportunity at the district court level to challenge the grounds upon which Respondent relied in seeking summary judgment. The law is well-settled that it was incumbent upon Petitioner to request a continuance to seek additional discovery pursuant to F.R.C.P. 56(f) if Petitioner believed that such

discovery was necessary to oppose Respondent's Motion for Summary Judgment. *See, e.g., Wallace v. Tilley*, 41 F.3d 296, 303 (7th Cir. 1994). To the extent that Petitioner needed additional time to conduct discovery in preparation of a response to Respondent's Motion for Summary Judgment, Petitioner was required to file an affidavit to that effect and seek relief pursuant to F.R.C.P. 56(f). Petitioner failed to do so, and cannot now raise issues which could and should have been resolved in the proceedings below. *See Chicago Florsheim Shoe Store Co. v. Cluett, Peabody & Co.*, 826 F.2d 725, 727 (7th Cir. 1987) (where plaintiff failed to seek relief under F.R.C.P. 56(f), appellate court cannot conclude that it was abuse of discretion to rule on summary judgment); *Hessel v. O'Hearn*, 977 F.2d 299, 305 (7th Cir. 1992) (where plaintiff failed to move for F.R.C.P. 56(f) continuance before lower court, raising the issue on appeal was "too late").

In her Petition for a Writ of Certiorari, Petitioner ignores the fact that she had a full and fair opportunity to litigate the merits of Respondent's interpretation of and reliance upon the terms of the Plan. In the proceedings below, Petitioner argued that Respondent's interpretation of the Plan terms was erroneous, and that the cosmetic exclusion and gastric exclusion did not preclude coverage for the benefits claimed by Petitioner. These arguments required the application of well-established law to the undisputed, albeit unique, facts of the case. Petitioner did not raise, and therefore, has waived her right to now challenge the propriety of Respondent's reliance upon the cosmetic exclusion as a basis for denial of Petitioner's claim for benefits. In addition, Petitioner ignores the fact that, in the Seventh Circuit, the omission from a final

denial letter of a basis for denial of a claim does not constitute a waiver of the terms of the Plan. *See Loyola University of Chicago v. Humana Ins. Co.*, 996 F.2d 895, 901 (7th Cir. 1993). Accordingly, Petitioner's argument is without merit and she cannot now seek to argue issues which were not properly raised in the proceedings below.

II. Summary Judgment In Favor Of Respondent Was Properly Entered By The District Court And Affirmed By The Court Of Appeals.

The United States District Court for the Central District of Illinois and the Seventh Circuit Court of Appeals appropriately reviewed Respondent's denial of Petitioner's claim for benefits under the arbitrary and capricious standard of review, and upheld Respondent's determination to deny benefits to Petitioner. It is undisputed in this case that Petitioner sought benefits for treatment directly related to her prior elective gastric bypass procedures. It is also undisputed that Petitioner was advised by Respondent in a letter, dated August 10, 1992, three years prior to the treatment at issue in this action, that any future surgery relating to her prior gastric bypass surgeries would not be covered. Based on a thorough analysis of Petitioner's medical records and other information, and the advice of an independent physician, Respondent appropriately determined that the benefits claimed by Petitioner were excluded by the terms of the Plan.

Petitioner did not contest the application of the arbitrary and capricious standard of review to the Respondent's decision to deny Petitioner's claim for benefits.

Under the arbitrary and capricious standard of review, a denial of benefits cannot be set aside if the denial was based upon a reasonable interpretation of the plan documents. *See, e.g., Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1021 (7th Cir. 1998), *cert. denied*, 119 S. Ct. 372, 142 L. Ed. 2d 307 (1998). Moreover, if a plan administrator makes an informed judgment and articulates an explanation for it that is satisfactory in light of the relevant facts, then the administrator's decision is final. *Loyola University of Chicago v. Humana Ins. Co.*, 996 F.2d at 989. Under the arbitrary and capricious standard, it is not the function of a reviewing court to decide whether it would reach the same conclusion as the Plan or even rely on the same authority. *Cvelbar v. CBI Illinois, Inc.*, 106 F.3d 1368, 1377 (7th Cir. 1997), *cert. denied*, 118 S. Ct. 56, 139 L. Ed. 2d 20 (1997), *abrogated on other grounds, International Union of Operating Engineers v. Rabine*, 161 F.3d 427 (7th Cir. 1998). Instead, under the standard articulated by the Seventh Circuit Court of Appeals, a reviewing court must uphold a denial of benefits unless the decision was "downright unreasonable." *Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d at 1021.

Under the arbitrary and capricious standard of review, Respondent's determination to deny benefits to Petitioner was appropriate in light of the terms of the gastric exclusion and cosmetic exclusion. The Committee made an informed judgment and articulated a rational explanation for its decision. The Committee gathered and analyzed all relevant information, evaluated and addressed Petitioner's arguments and concerns, reviewed and evaluated the arguments and opinions of her treating

physician and counsel, and was advised by an outside medical consultant. The Committee adopted a reasonable interpretation of the Plan, and reached a judgment that was informed and supported by sound rationale. The determination by Respondent to deny Petitioner's claim for benefits was not "downright unreasonable," and was appropriately upheld by the United States District Court for the Central District of Illinois and the United States Court of Appeals for the Seventh Circuit.

CONCLUSION

This case does not present any "important question of federal law" which must be resolved by this Court. Nor does this case involve any federal constitutional issue or seek to resolve a division of opinion between any of the circuit courts of appeals. The principles of law applicable to a review of benefits under ERISA are well-settled, and were applied appropriately by the courts below in upholding Respondent's denial of Petitioner's claim for benefits. Moreover, Petitioner has waived her right to challenge in this Court the propriety of Respondent's reliance upon the cosmetic exclusion as one of the bases for denial of Petitioner's claim for benefits due to her failure to raise the issue in the proceedings below.

Respondent accordingly requests that this Court deny the Petition for a Writ of Certiorari.

Respectfully submitted,

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